



**AGREEMENT FOR RELEASE OF VITAL STATISTICS DATA TAPES  
CONTAINING CONFIDENTIAL INFORMATION**

State Form 44384 (R/11-07)  
INDIANA STATE DEPARTMENT OF HEALTH

## **INSTRUCTIONS:**

1. In Compliance with IC16-37-1-10 and ISDH Policy Memo 1-7, you are required to provide the following information.
  2. This agency may be unable to process your request without this information. Upon completion this form will become a PUBLIC RECORD

**Information Requested (List Title)**

### Purpose of Request

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**Name of Requestor**

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**Job Title**

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**Street Address**

**City, State, ZIP CODE**

As a condition of receiving vital statistics data tapes/ CD's I/we agree that:

1. I/we shall use this information only for the purpose of the approved research study or activity stated above.  
(Unauthorized use may cause the Indiana State Department of Health to deny any further request for data tapes/CD.)
  2. The information requested is confidential pursuant to IC 16-37-1-10(a)(3) and I/we shall not publish or release the names of individuals or any facts tending to lead to the identification of individuals named in the data tapes/CD's.
  3. None of the information provided in these data tapes/CD's will be used for commercial or charitable solicitation.
  4. I/we guarantee that the confidentiality of the information provided by these data tapes/CD's will be maintained, and that none of the information provided in these data tapes/CD's will be used for the purpose of conducting follow-up contact with the survivors, family or physicians unless expressly authorized by the Indiana State Department of Health.
  5. I/we shall provide the Indiana State Department of Health with a written plan of action for final disposition of these data tapes/CDs upon completion of the specified research activity
  6. I/we shall pay actual costs (including staff time, materials, or interagency charges) of copying this information for my/our use.
  7. The State Department of Health may cancel this agreement if it believes that use does not serve the public interest. The State Department of Health will however, give written notice stating the reason(s). Upon receiving this notice, I/we shall cease using the data tapes/Cds and shall destroy any copy of the data tapes/CDs I/we hold.
  8. I/we may cancel this agreement by notifying the State Department of Health in writing and by destroying any copy of the data tapes/CDs we have.
  9. This agreement is effective when an authorized representative of the State Department of Health signs it.
  10. Failure to comply with these conditions constitutes a breach of contract and could result in civil action by data subject(s) per IC 4-1-6-8.6

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**Signature of Requestor**

Date (*month, day, year*)

## **STATE AGENCY USE**

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### Request Approved/Disapproved/Referred to Executive Board

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Printed Name of Authorizing Official

**Job Title**

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**Signature of Authorizing Official**